Dental Billing: Using the ADA 2012 Claim Form

Indiana Health Coverage Programs
DXC Technology
ADA Web Training



Session Objectives



- Preview the new ADA 2012 Dental Claim Form requirements and changes
- Explain the new fields on the Provider Healthcare Portal related to the update
- Review the 837D format requirements
- Helpful tools
- Q&A



ADA 2012 Claim Form

- The new form will be effective based on date received; effective date to be announced
- For more information, see BR201818
- Watch upcoming publications from the IHCP for more information
- Changes to be published in the Dental Services provider reference module at next update
- Although some fields are "optional," the information entered in the fields will be validated to ensure the data entered is appropriate

IHCP PROVIDER REFERENCE MODULES

The IHCP Provider Reference Modules replace the former IHCP Provider Manual and supplemental provider manuals. For help finding information that has moved from the provider manuals to the IHCP Provider Reference Modules, see the IHCP Provider Manuals/Provider Reference Modules Crosswalk.

Jump to Eligibility and Benefits Modules

Jump to Claims and Billing Procedures Modules

Jump to Service- and Provider-Specific Modules

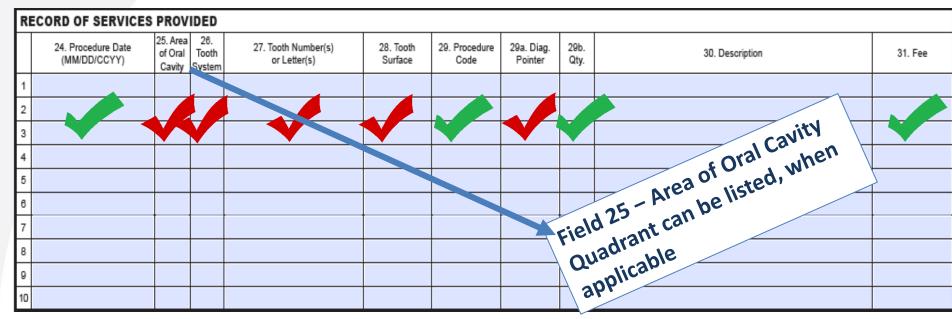
Jump to Program-Specific Modules

	Effective Date*	Version
General Information Modules		
Introduction to the IHCP	June 1, 2017	2.0
Interactive Voice Response System	October 1, 2017	2.0
Prior Authorization	February 1, 2018	3.0
Provider and Member Utilization Review	September 1, 2017	2.0
Provider Enrollment	September 1, 2017	2.0
Provider Healthcare Portal	July 1, 2017	2.0
Eligibility and Benefits Modules		
Member Eligibility and Benefit Coverage	September 1, 2016	1.1
Presumptive Eligibility	June 1, 2017	2.0

Fields 1, 20, and 23 – Header Information, Patient Information

ADA American Dental Association® Dental Claim Form	1
HEADER INFORMATION	
Type of Transaction (Mark all applicable boxes) Statement of Actual Services Request for Predetermination/Preauthorization EPSDT / Title XIX	
Predetermination/Preauthorization Number	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)
	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	
3. Company/Plan Name, Address, City, State, Zip Code	IHCP member last name, first name
	13. Date of Birth (MM/DD/CCYY) 14. Gender Member Medicaid number
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)	16. Plan/Group Number 17. Employer Name
4. Dental? Medical? (If both, complete 5-11 for dental only.)	
Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	PATIENT INFORMATION
	18. Relation ship to Policyholder/Subscriber in #12 Above 19. Reserved For Future
Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)	Sel Spouse Dependent Child Other
M F	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
9. Plan/Group Number 10. Patient's Relationship to Person named in #5 Self Spouse Dependent Other	IHCP member last name, first name
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	
	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Dentist) Office internal patient number

Fields 24 – 31 Service Details





= Required field for ALL claims



= Required field, if applicable

If Field 29a (Diagnosis Pointer) is entered, Field 34 Diagnosis Code Qualifier and 34a Diagnosis Code MUST be completed. (See Slide 8.)



Field 25 – Oral Cavity Codes Accepted

Code	Description
L	Left
R	Right
00	Entire Oral Cavity
01	Maxillary Area
02	Mandibular Area
09	Other Area of Oral Cavity
10	Upper Right Quadrant
20	Upper Left Quadrant
30	Lower Left Quadrant
40	Lower Right Quadrant

These codes will be required for some procedure codes. Please monitor future bulletins and banners for more information.

Field 31A – Other Fees

DECORD OF SERVICES PROVIDED																							
RECORD OF SERVICES PROVIDED																							
				ure Date CCYY)	2	25. Are of Ora Cavity	1 1	26. Tooth ystem		27	. Toot or l	h Nu Letter		(s)			8. Too Surfac		29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1																							
2																							
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9																							
10																							
33	3. M	issing Te	eth I	Informa	tion	(Place	an	"X" oı	n eac	ch mi	issing	g too	th.)					34	. Diagnosis Code	List Qualifier		(ICD-9 = B; ICD-10 = AB) 310 Cure	
	1	2	3	4	5	6 7		8 9	9	10	11	12	13	14	15	1	6	34	a. Diagnosis Cod	e(s)	Α	Fee(s)	
	32	31 3	30	29 2	8 2	27 26	2	25 2	4 2	23	22	21	20	19	18	1	7	(P	rimary diagnosis	in "A")	В	D	₩ U.00
35	5. R	emarks																					

31a. Other	
Fee(s)	

No information should be entered in this field



Fields 34 and 34a – Diagnosis Qualifier and Diagnosis Code

34. Diagnosis Code List Qualifier		(ICD-9 = B; ICD-10	= AB)
34a. Diagnosis Code(s)	Α_	c	
(Primary diagnosis in "A")	В_	D	

- New fields for ADA 2012
- Fields 34 and 34a are optional
 - Required if Field 29a (Diagnosis Pointer) is completed
- Field 34 When applicable, enter the diagnosis qualifier of AB
 - Qualifier AB indicates an ICD-10 diagnosis will be entered in Field 34a
- Field 34a If a diagnosis qualifier is indicated, a diagnosis code MUST be entered



Field 35 - Remarks Field

- As in the past, this field is required to report primary insurance payment
- Enter <u>ONLY</u> the amount paid
 - Paid amount can be handwritten in Black ink

35. Remarks



Fields 38-47 — Ancillary Claim/Treatment Information

ANCILLARY CLAIM	l/TRE	ATMENT INFORMATION							
38. Place of Treatment		(e.g. 11=office; 22=O/P Hospital)	39. Enclosures (Y or N)						
(Use *Place of Ser	vice Cod	des for Professional Claims")							
40. Is Treatment for Orth	nodonti	cs?	41. Date Appliance Placed (MM/DD/CCYY)						
No (Skip 41-4	42)	Yes (Complete 41-42)							
42. Months of Treatment	t 43	3. Replacement of Prosthesis	44. Date of Prior Placement (MM/DD/CCYY)						
		No Yes (Complete 44)							
45. Treatment Resulting from									
Occupational	illness/	/injury Auto acciden	ıt [Other accident					
46. Date of Accident (MI	M/DD/C	CCYY)		47. Auto Accident State					

- Field 38 is a NEW required field
- Fields 39 47 are required, if applicable
- Field 47 is a required field only if Field 45 indicates an auto accident



Fields 48, 49 and 52a – Group or Billing Location

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

Enter the service location as listed on the provider enrollment profile

49. NPI Group or billing provider NPI

50. License Number

51. SSN or TIN

52. Phone Number 52a. Additional Provider ID

Taxonomy related to group or billing provider location



Field 54 – Rendering Provider

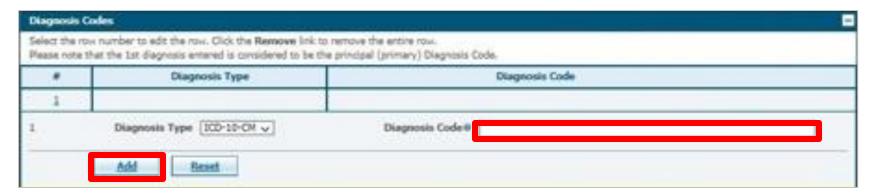
TREATING DENTIST AND TREATMENT LOCATION INFORMATION										
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.										
Х	>									
Sig	ned (Treating Dentist)			Date						
54. NPI	Rendering provider NPI	55. Lice	nse Number							
56. Addre	ess, City, State, Zip Code	56a. Pro Specialt								
57. Phon Numb		58. Addi Prov	tional /ider ID							

- Field 54 Enter the NPI of the provider rendering the services
 - This NPI will be the same as the NPI of the billing provider in field 49, unless the billing entity is a group.
 - If the billing entity is a group, the rendering provider must be linked to the group's enrollment.

New Fields – Provider Healthcare Portal



Diagnosis Codes (optional)



If reporting diagnosis codes, type the code in the Diagnosis Code box and click "Add"



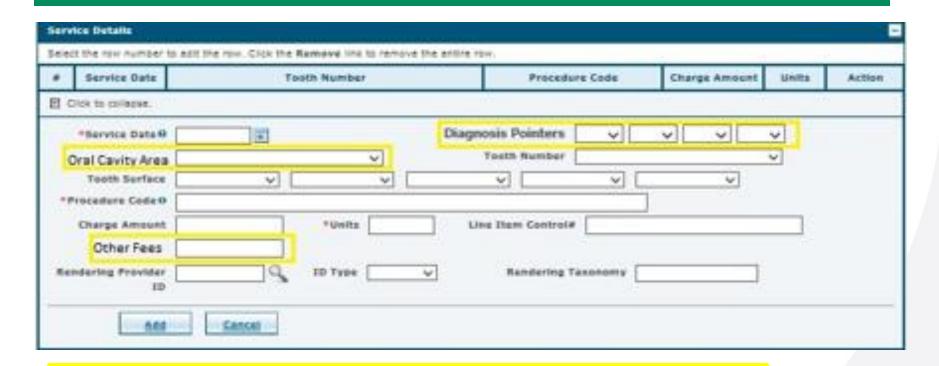
Missing Teeth (optional)



If reporting missing teeth, type the tooth number in the box and click "Add"



Service Details – New Fields



- New fields
- Diagnosis pointers Required if diagnosis codes are entered in header (use of diagnosis codes is optional)
- Oral cavity area Not required
- Other fees NO information should be entered in this field.

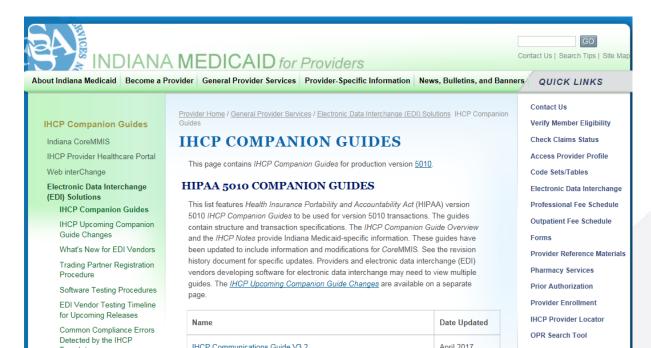


837D Transactions



837D Requirements

- Contact your system vendor about changes related to the new form that may be required for billing to the IHCP
 - The Companion Guide will be available on the <u>IHCP Companion</u> <u>Guides</u> page at www.indianamedicaid.com
- Contact the EDI Unit at DXC Technology for additional information
 - 1-800-457-458**4**



Helpful Tools

- IHCP website at indianamedicaid.com
 - IHCP Provider Reference Modules
 - Medical Policy Manual
- Customer Assistance available 8 a.m.— 6 p.m. EST Monday — Friday
 - 1-800-457-4584
- IHCP Provider Relations Field Consultants
 - See the <u>Provider Relations Field Consultants</u> page at indianamedicaid.com
- Secure correspondence via the Provider Healthcare Portal
- Written Correspondence
 - DXC Technology Provider Written Correspondence
 P.O. Box 7263
 Indianapolis, In 46207-7263





Questions

